No. 97-689

In the
Supreme Court of the United States
OCTOBER TERM, 1997

BONNIE L. GEISSAL, as representative of the Estate of JAMES W. GEISSAL, deceased,
Petitioner,

v.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP., and HERBERT WALKER,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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MOTION FOR LEAVE TO FILE A BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE A BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION

The American Association of Retired Persons (AARP) and the National Employment Lawyers Association (NELA) move for leave to file the accompanying brief *amici curiae* in support of the position of petitioner Bonnie L. Geissal, whose case is before the Court on a writ of certiorari from the judgment and opinion of the United States Court of Appeals for the Eighth Circuit.

Pursuant to Supreme Court Rule 37.3, consent of the parties to the filing of the brief was sought through counsel. Counsel for the petitioner gave consent, but counsel for the respondents withheld consent.

INTEREST OF *AMICI CURIAE*

The American Association of Retired Persons (AARP), a nonprofit membership organization of more than 32 million Americans age 50 or older, some working and some retired, is dedicated to addressing the needs and interests of older people. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all citizens. In the effort to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage, from both public and private sources.

The National Employment Lawyers Association (NELA) is a voluntary membership organization of over 3,000 attorneys who regularly represent employees in labor,

employment, and civil rights disputes. It is the country's only professional membership organization exclusively comprised of lawyers who represent employees in cases involving employment discrimination, employee benefits, wrongful discharge, and other employment-related matters. As part of its advocacy efforts, NELA regularly supports precedent-setting litigation affecting the rights of individuals in the workplace.

AARP and NELA are qualified to brief the Court on this matter, as they have participated as *amici curiae* in numerous cases involving the Employee Retirement Income Security Act (ERISA), including *Boggs v. Boggs*, 117 S.Ct. 1754 (1997); *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 117 S.Ct. 1513 (1997); and *Varity Corp. v. Howe*, 116 S.Ct. 1065 (1996).

AARP's members and the clients of NELA members depend in general on ERISA to protect their rights under private employer-sponsored benefit plans, 29 U.S.C. § 1001 *et seq.*, and in particular on the health care coverage protections afforded in amendments to ERISA made by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), 29 U.S.C. §§ 1161-1168. The *amici* therefore have a strong and determined interest in the outcome of this case and in ensuring, to the extent possible, that the rights guaranteed by ERISA and COBRA are fully carried out.

REASONS FOR GRANTING THE MOTION

In this instance, one of the COBRA "continuation coverage" provisions, 29 U.S.C. § 1162, which is designed to offer individuals the option of maintaining their packages of group health plan coverage after leaving employment, has been ignored or misinterpreted by three appellate courts. As a result, departing employees with already existing coverage under other

group plans are denied their right to opt for continuation coverage. If this decision is upheld, workers who leave their employment will face exactly the problem which continuation coverage was designed to avoid: the prospect of sometimes devastating medical bills because of the inability to obtain, or afford, individual health insurance.

This case presents the Court with the opportunity to carry out legislative intent which Congress expressed in precise statutory language. The decision will have a direct bearing on the economic and health security of millions of Americans, including members of AARP and clients of NELA members. In light of the significance of the issue presented, AARP and NELA request that the Court grant this motion to file their brief *amici curiae*.

Respectfully submitted,

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March 1998

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

LEGISLATIVE HISTORY

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BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF PETITIONER

INTEREST OF *AMICI CURIAE*[1/]

The interest of *amici* is set forth in the accompanying motion for leave to file this brief.

SUMMARY OF ARGUMENT

By its plain meaning, its placement, and its context, the relevant section of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986), continuation coverage provisions establishes unequivocally that continuation coverage may be terminated only when other coverage is obtained *after* continuation coverage begins. The relevant language is in a subsection titled "Period of Coverage", which states a general rule for the duration of the COBRA option. Within that subsection, four exceptions allow early termination of continuation coverage. The exception at issue permits termination only on "[t]he date on which the qualified beneficiary *first becomes, after the date of the election* [of continuation coverage] ... covered under any other group plan...." 29 U.S.C. § 1162(2)(D)(i) (emphasis supplied).

Three appellate courts have ignored this precise and unambiguous language and structure. To reach their conclusion that existing other coverage precludes the option for continuation coverage, they employ a linguistic sleight of hand, pretending that termination occurs instantaneously upon

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[1/] With the exception of the fact that counsel for petitioner, S. Sheldon Weinhaus, and counsel for the respondents, Bradley J. Washburn, are members of the National Employment Lawyers Association, and, as such, pay general membership dues, no persons other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

election of continuation coverage. This reading is based on one line of legislative history, which states only a Congressional concern for those with no health insurance, but ignores the broader legislative intent of offering all departing employees the opportunity to maintain the status quo of their health coverage.

Those courts' determination to rewrite the statute is underscored by their use of the "significant gap" exception. Under this entirely judge-made approach, a few individuals with existing coverage do not lose the right to select continuation coverage. The standards for the exception's application, however, are unclear and unworkable, and place the initial and primary burden on employers, not courts.

ARGUMENT

THE STATUTE'S PLAIN MEANING IS THAT THE RIGHT TO PAY FOR AND RECEIVE CONTINUATION COVERAGE IS NOT AFFECTED BY EXISTING COVERAGE UNDER ANOTHER PLAN.

By allowing an inference drawn from a few general words of legislative history to trump the precise language of the statute, *see Geissal v. Moore Medical Corp.*, 114 F.3d 1458, 1463-1464 (8th Cir. 1997), *cert. granted*, 118 S.Ct. 877 (1998), the court below ignored a fundamental precept of statutory construction: "The starting point for interpretation of a statute 'is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive.'" *Kaiser Aluminum & Chemical Corp. v. Bonjorno*, 494 U.S. 827, 835 (1990), quoting *Consumer Product Safety Commission v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980). In the absence of

explicit legislative history which directly refutes the language of the statute, courts have no basis "to question the strong presumption that Congress expresses its intent through the language it chooses." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 433 n.12 (1987). Just as "the plain language" of another provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, led last Term to only one possible conclusion, *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 117 S.Ct. 1513, 1515 (1997), so too do these canons of construction require the determination that having other coverage is not an exception to a departing employee's right to select continuation coverage under the statute.

A. The Placement and Context of the Relevant Statutory Language Support its Plain Meaning.

"[M]indful that the language of a statute controls when sufficiently clear in its context," *Ernst & Ernst v. Hochfelder*, 425 U.S. 185, 201 (1976), *amici* will first provide a brief overview of the COBRA amendments in general and the specific provision at issue. Amending ERISA, the Public Health Service Act, and the Internal Revenue Code in 1986, Pub.L. No. 99-272, 100 Stat. 82 (1986), COBRA mandated continuation coverage for private and public employees.[2/]

[2/] The courts have analyzed the virtually identical COBRA provisions in ERISA and the Public Health Service Act without distinction. *See, e.g., Geissal*, 114 F.3d at 1461 n.6; *Brock v. Primedica, Inc.*, 904 F.2d 295, 296-297 (5th Cir. 1990); *Oakley v. City of Longmont*, 890 F.2d 1128, 1130 n.4 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990). Because this and most other reported decisions involve the ERISA version of the COBRA amendments, references will be to the relevant portion of ERISA, 29 U.S.C. §§ 1161-1168. The analog in the Public Health

(continued...)

Section 1161 sets out that a health plan must offer a "qualified beneficiary" the right "to elect ... continuation coverage under the plan," 29 U.S.C. § 1161(a), and the next section, 1162, provides the details of continuation coverage. *Id.*, § 1162. Section 1163 defines the "qualifying events" which trigger the right to continuation coverage; the most common of these is, as in this case, "[t]he termination ... of the covered employee's employment." 29 U.S.C. § 1163(2).

Section 1162, the section at issue, is titled "Continuation coverage", and its five subsections establish the core requirements, 29 U.S.C. §§ 1162(1)-(5), of which the first two are the most important for this discussion. Subsection 1 requires the continuation coverage to be "identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred,"[1] which ensures that departing employees will receive the same coverage as those who remain employed.

Subsection 2 sets out the "[p]eriod of coverage". Its structure -- the context in which the language at issue must be evaluated -- is simple: continuation coverage must "begin[ ] on the date of the qualifying event and end[ ] not earlier than the earliest of the following" five possible events. 29 U.S.C. § 1162(2). The first of the five events is the "[m]aximum required period", which is 18 months under the "[g]eneral rule for terminations and reduced hours", *id.*, § 1162(2)(A)(i), and 36 months in the other circumstances. *Id.*, §§ 1162(2)(A)(ii)-(v). The remainder of subsection 2 lists four instances in which

[1] (...continued)
Service Act is codified at 42 U.S.C. §§ 300bb-1 to -8.

this general period of coverage could be cut short, including the one at issue, "Group health plan coverage or Medicare entitlement". *Id.*, §§ 1162(2)(B)-(E).

Congress thus established a precise, three-part timetable for continuation coverage: (1) It begins with a qualifying event (usually, termination of employment) and (2) generally lasts either 18 or 36 months, but (3) there are exceptions to that durational rule.

In relevant part, the exception at issue, subsection (2)(D), now reads:

> The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than ... [t]he date on which the qualified beneficiary first becomes, after the date of the election --
>
> > (I) covered under any other group plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary ..., or (ii) in the case of a [certain type of] qualified beneficiary ..., entitled to [Medicare] benefits....

29 U.S.C. § 1162(2)(D).[2] Although there have been two

[2] Although most cases on the issue are in the context of existing coverage under a group health plan, as set out in subsection (2)(D)(i), eligibility for Medicare, which is codified at subsection (2)(D)(ii), presents an analytically undifferentiated issue. *King v. John Hancock Mutual Life Insurance Co.*, 500 N.W.2d 619, 622 (S.D. 1993) (existing Medicare coverage does not preclude right to COBRA continuation coverage).

amendments since its passage,[4] Congress has never amended the introductory language which is at the heart of this case: "[t]he date on which the qualified beneficiary first becomes, after the date of the election...." 29 U.S.C. § 1162(2)(D).

B. The Plain Meaning of the Language Does Not Permit Treatment of Existing Coverage as a Terminating Event.

The structure of section 1162(2) offers no indication that Congress contemplated that any of the early-termination dates could occur before the qualifying event that begins the "maximum required period." Furthermore, for the specific provision at issue Congress employed language which could only refer to a point in time coming *after* continuation coverage had begun: "[t]he date on which the qualified beneficiary *first becomes, after the date of the election....*" 29 U.S.C. § 1162(2)(D) (emphasis supplied). There can be no doubt as to the timing which Congress intended: termination may take place when the qualified beneficiary initially becomes eligible for other coverage after selecting continuation coverage.

The statute is explicit that a terminating event may only occur after continuation coverage has begun. First, because the "election period ... begins not later than the date on which coverage terminates under the plan by reason of a qualifying

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[4] The first amendment changed the language in subsection (2)(D)(i) from "(i) a covered employee under any other group plan" to "(i) covered under any other group health plan (as an employee or otherwise)." Pub.L. No. 99-514, § 1895(d)(4)(B)(ii), 100 Stat. 2085, 2938 (1986); *see Oakley*, 890 F.2d at 1132. In 1989, Congress added the following language at the end of subsection (2)(D)(i): "which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary ...." Pub.L. No. 101-239, § 7862(c)(3)(B)(ii), 103 Stat. 2106, 2432 (1989).

event," 29 U.S.C. § 1165(1)(A), the phrase "after the date of the election" refers to a point in time after the qualifying event. Second, the phrase "first becomes" ("covered under any other group health plan" or "entitled to [Medicare] benefits") is an unambiguous reference to establishing eligibility for the other coverage for the *first* time. Congress was as clear as it possibly could be, and the "ordinary and obvious meaning of the phrase is not to be lightly discounted." *Cardoza-Fonseca*, 480 U.S. at 431 (citations omitted).

If the obligation to "giv[e] the 'words used' their 'ordinary meaning'" is to be taken seriously, *Moskal v. United States*, 498 U.S. 103, 108 (1990) (citation omitted), then the references to the qualified beneficiary *first* becoming covered under a new plan *after* the date of election may not be ignored. The plain meaning of the statute could not be more apparent. *Lutheran Hosp. of Indiana, Inc. v. Business Men's Assurance Co. of America*, 51 F.3d 1308, 1312 (7th Cir. 1995); *Oakley*, 890 F.2d at 1132; *King*, 500 N.W.2d at 621-622.

For judges determined to conclude otherwise, the solution to this unambiguous language has been largely to ignore it, or to dismiss it as mere "grammar and syntax". *Lutheran Hosp.*, 51 F.3d at 1315 (Coffey, J., dissenting). Thus, the Eleventh Circuit, which the court below quoted at length and "explicitly follow[ed]," *Geissal*, 114 F.3d at 1463, declined to analyze the statutory language, choosing instead to declare the intent of Congress and then to conclude, based on that intent, that "it is clearly irrelevant whether an employee had other group health coverage prior to this election date...." *National Cos. Health Benefit Plan v. St. Joseph's Hosp. of Atlanta, Inc.*, 929 F.2d 1558, 1570 (11th Cir. 1991); *see also Brock*, 904 F.2d at 297 (denying the right to continuation coverage because of existing coverage, without discussing the relevant statutory language).

These courts' only attempt to come to terms with the actual words of Congress underscores their inability to construct a framework compatible with that language and its context. They contend that, for employees with existing coverage, the words "first becomes" refer to a metaphysical point in time, the very instant of election: "[T]he terminating event occurs immediately; the first time after the election date that the employee becomes covered by a group health plan other than the employer's plan is the moment after the election date." *National Cos.*, 929 F.2d at 1570. For the petitioner, therefore, who "became covered under his wife's plan ... the very moment after the election date," *Geissal*, 114 F.3d at 1464, continuation coverage was so fleeting that it could not be measured even by an atomic clock. This is a studied attempt to devise an "acceptable" meaning from language which cannot support it.

Although this semantic game-playing is critical to the decision below, it does not comport with either the structure or the language of COBRA. It would have been a simple act of draftsmanship for Congress to include a provision denying continuation coverage to those with other coverage, *see, e.g., Inter-Modal Rail Employees Ass'n*, 117 S.Ct. at 1515 ("Had Congress intended ..., it could have easily...."), but there is no such language: "The statute does not say that an employee is ineligible for continuation coverage if he or she is covered by a preexisting group health plan." *Lutheran Hosp.*, 51 F.3d at 1312.

The framework on which the court below and others have based their conclusions in contradiction to the explicit statutory language is their view of Congressional intent. Putting aside that the language is sufficiently unambiguous -- even redundantly so -- that legislative history need not even be considered, *see, e.g., Toibb v. Radloff*, 501 U.S. 157, 162

(1991), it is evident that these courts have improperly narrowed the intent of Congress.

Although there is no legislative history on the specific provision at issue, *Lutheran Hosp.*, 51 F.3d at 1313, the courts all cite a portion of one sentence from the legislative history: "The COBRA amendments were enacted in response to 'reports of the growing number of Americans without any health insurance coverage....' H.R.Rep. No. 241, 99th Cong., 2d Sess. 44...." *National Cos.*, 929 F.2d at 1567; *see also Geissal*, 114 F.3d at 1463; *Brock*, 904 F.2d at 296. From this one statement, they infer that COBRA had only one purpose, and that purpose drives their interpretation of the provision at issue. *Geissal*, 114 F.3d at 1463-1464; *National Cos.*, 929 F.2d at 1570; *Brock*, 904 F.2d at 296-297.

This one small portion of legislative history, however, cannot effect a result at odds with the statute itself. First, a general concern for those without health insurance cannot trump explicit statutory language regarding the applicability of continuation coverage: "[V]ague notions of a statute's 'basic purpose' are ... inadequate to overcome the words of its text regarding the *specific* issue under consideration." *Mertens v. Hewitt Associates*, 508 U.S. 248, 261 (1993) (citation omitted). Secondly, even if Congress were reacting primarily in response to those without health insurance, there is no inconsistency in also including those with other coverage: "The fact that Congress may have been motivated by the plight of a smaller sub-class -- people without any health insurance -- does not mean that in remedying the situation they necessarily limited relief to that sub-class rather than the larger group...." *Lutheran Hosp.*, 51 F.3d at 1313 n.5.

There is simply no indication that Congress was against allowing those with existing coverage to have continuation

coverage, or that to do so was inconsistent with the purpose of the COBRA amendments. Indeed, the more logical reading is that including those with other coverage within the continuation coverage option fit the general legislative pattern of providing departing employees with the choice of deciding how to proceed: "[E]ach qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect ... continuation coverage under the plan." 29 U.S.C. § 1161(a). In this respect, continuation coverage is a means of preserving "the beneficiary's health care status quo." *Lutheran Hosp.*, 51 F.3d at 1312. If the departing employee has no coverage at the time that employment is terminated, then he or she has the choice of paying the full premium in order to maintain that coverage. If he or she has other coverage, there is a comparable decision to be made: whether to rely solely on the dependent's coverage provided through the spouse's employment, or to pay the full premium for the eighteen months of continuation coverage in order to maintain whatever advantages, in the departing employee's view, the continuation coverage may provide.

That maintenance of the "health care status quo" for a limited period of time was an overall Congressional goal is demonstrated by two other aspects of the COBRA amendments. First, subsection 1162(1) requires that the continuation coverage be "identical" to the coverage provided to those "similarly situated beneficiaries" who have not left employment. Secondly, in a similar effort to guarantee that a departed employee would not suffer a reduction in coverage as a consequence of leaving employment, Congress amended subsection 1162(2)(D)(i) in 1989. This amendment precluded plans from terminating continuation coverage upon a departed employee's becoming eligible for new coverage if the new plan included a limitation for a preexisting condition. H.R.Rep. No.

247, 101st Cong., 1st Sess. 1453 (1989), *reprinted in* [1989] U.S. Code & Cong. News 1906, 2923.

C. The Failure to Accept the Plain Meaning of the Statutory Language Has Led Courts to Fabricate the "Significant Gap" Exception, Which Underscores Their Misinterpretation of the Statute.

Yet another factor underscores the mistake of the court below: the unworkable, judge-made "significant gap" exception, which has been cobbled together to ameliorate some results from denying continuation coverage to those with other coverage. Under this analysis, which has developed over the eight years since its inception,[5/] once a court has held that COBRA does not generally permit continuation coverage for those with existing coverage, it must then determine whether there was a "significant gap" between the existing coverage and the continuation coverage. *See, e.g., Geissal,* 114 F.3d at 1464. The stated rationale for this fiction is that, "[i]f there is a significant gap between the coverage afforded under his employer's plan and his preexisting plan, ... the employee is not truly 'covered' by the preexisting group health plan ...; the employee, despite his other coverage, will be liable personally for substantial medical expenses to his and his family's detriment." *National Cos.*, 51 F.3d at 1571.[6/]

[5/] Although the "gap" analysis actually had its genesis as *dictum* in the first decision concluding that the COBRA amendments did *not* deny continuation coverage to those with existing coverage, *see Oakley,* 890 F.2d at 1133, it was first applied in *Brock,* 904 F.2d at 297.

[6/] Attempting to divine some legislative authority for the "significant gap" exception, courts have suggested that it is supported by the 1989 amendment to subsection 1162(2)(D)(i), which precluded the termination

(continued...)

In addition to lacking any statutory basis, the "significant gap" exception has another drawback: its application is, and always will be, unclear and cumbersome, creating an erratic and wholly subjective standard which is nearly impossible to apply. One district judge, for instance, recently discerned three possible methodologies. *Schlett v. Avco Financial Services, Inc.*, 950 F.Supp. 823, 832-833 (N.D.Ohio 1996); *see also, e.g., Lutheran Hosp. of Indiana, Inc. v. Business Men's Assurance Co. of America*, 845 F.Supp. 1275, 1288-1289 (N.D.Ind. 1994), *rev'd*, 51 F.3d 1308 (7th Cir. 1995). Consequently, although the Eleventh Circuit held that an out-of-pocket payment of $6,700 for medical expenses because of the denial of continuation coverage did not create a "significant gap", *National Cos.*, 51 F.3d at 1571, an Eighth Circuit panel believed that a $6,500 gap was "significant" enough to trigger the exception. *McGee v. Funderburg*, 17 F.3d 1122, 1126 (8th Cir. 1994) (*dictum*). This discrepancy prompted the Seventh Circuit to ask: "Does the magnitude of personal liability sufficient to constitute a gap depend on the ability of the individual to pay or on the overall scale of their medical expenses?" *Lutheran Hosp.*, 51 F.3d at 1314 (footnote omitted).

The court below, however, rejected these *post hoc* analyses of medical expenses incurred by departed employees, directing district courts instead to

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[6] (...continued)
of continuation coverage when the newly obtained coverage had an exclusion for a preexisting condition. *See, e.g., Geissal*, 114 F.3d at 1464 n.10. But the gaps at issue in the "significant gap" analysis are the result of coverage differences between two plans, and are unrelated to the preexisting condition problem remedied by the 1989 amendment. *Lutheran Hosp.*, 51 F.3d at 1314. The courts appear to confuse preexisting plans with preexisting conditions.

> measure the gap by comparing the policies' provisions in light of information available to the employer on the day of the COBRA election.... [T]he court should examine the policies "to determine their benefits, whether there is any exclusion or limitation on the patient's preexisting condition, and with a view to the treatment the beneficiary may foreseeably require."

Geissal, 114 F.3d at 1465 (citation to interior quotation omitted). That is, a district judge must compare the policies and also evaluate the former employee's past health in order to estimate what medical expenses might be anticipated in the future. It is a staggering charge, and requires the district court to make medical prognostications based on past diagnoses. In addition, the courts must fashion and apply appropriate standards of review. *Cf. Lutheran Hosp.*, 51 F.3d at 1315 ("Is the court to apply an objective or subjective standard, i.e., is it what the employer knew or what a reasonable employer should have known?").

The final unworkable component of this "morass", *id.*, is that most of the decision-making will be carried out not by judges, but by employers. Indeed, that is precisely the reason why the court below rejected the *post hoc* approach: it "gives too little guidance to employers who must decide, on the front end, whether termination of COBRA benefits is warranted." *Geissal*, 114 F.3d at 1464-1465 (citation omitted). Thus, the employer of a departing employee with other coverage decides, at the time of departure, whether the difference in coverage is sufficient to warrant invocation of the exception. In so doing, the *employer* not only embarks upon a quasi-legal comparison of the policies, but also evaluates the individual's medical condition in order to estimate the extent of anticipated future medical expenses. With the employer thus forced to play both lawyer and doctor, the inherent problems posed by this jerry-

rigged mechanism seem endless and irresolvable: "How does an employer calculate the gap based on whatever information he is presumed to have? Must an employer utilize an actuary and medical expert to determine the likely effect of policy differences given the patient's physical condition at the time of the qualifying event?" *Lutheran Hosp.*, 51 F.3d at 1315.

This bizarre product of a determination to ignore statutory language in favor of some courts' view of legislative intent only serves to demonstrate the flaws in reasoning which generated it. There is no need, however, to consider the complexities and problems created by the "significant gap" exception; the issue is resolved by simply applying the plain meaning of the statute, which will carry out Congress' intent to allow each employee to choose how best to maintain the status quo: "The only gap that should be relevant and judicially cognizable is that perceived by the insured individual who chooses to pay the COBRA premiums to continue her additional coverage." *Id.* at 1314.

CONCLUSION

For the reasons stated, *amici* urge the Court to reverse the decision below and to hold that 29 U.S.C. § 1162(2)(D) permits qualified beneficiaries with existing coverage to elect and maintain COBRA continuation coverage.

Respectfully submitted,

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